HEALTH CARE FACILITY 12/08/2010 09:32 8655945739 FORM APPROVED DEPARTMENT OF HEALTH AND HL N SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER: AND FLAN OF CORRECTION a, building B. WING. 12/02/2010 445419 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 318 BILBREY STREET OVERTON COUNTY NURSING HOME LIVINGSTON, TN 38570 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (XII) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X4) ID PREFIX DATE TAG: TAG F 000 INITIAL COMMENTS F 000 An annual recertification survey and complaint investigation #26610 and #27122 were completed on November 30 - December 2, 2010, at Overton County Nursing Home. No deficiencies were cited related to complaint investigation #26610 under 42 CFR PART 482, Requirements for Long Term Care. Deficiencies were cited related to complaint investigation #27122. 488.20(d)(3), 483.10(k)(2) RIGHT TO F 280 F 280 PARTICIPATE PLANNING CARE-REVISE CP SS=D The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced Based on medical record review and interview the facility failed to update the care plan to reflect changes in resident care for three residents (#6, (XB) DATE VABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE 12-16-10 Any deficiency statement ending with an astorisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that Athery staguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

following the date of survey whether or not a plan of correction is provided. For aursing homes, the above findings and plans of correction are disclosable 14 days following the date beese documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program perticipation.

Facility ID: TN6702

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HEALTH CARE FACILITY

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PRINTED: 12/09/2010
FORM APPROVED
OMB NO 0028-0301

| DEPART                   | MENT OF HEALTH   | AND h AN SERVICES   |                   |                |  | FORM A                   | VPPROVED<br>0938-0391 |
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| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIERCLIA (IDENTIFICATION NUMBER:  | 1                 | ULTIP<br>LDING | LE CONSTRUCTION  | (X2) DATE SUI<br>COMPLET | RVEY                  |
|                          |  | 445419  | B, W              | NG             |  | 12/02                    | /2010                 |
|                          | ROVIDER OR SUPPLIER  | HOME  | ,                 | 31             | EET ADDRESS, CITY, STATE, ZIP CODE<br>IS BILBREY STREET<br>WINGSTON, TN 38578  |                          | -                     |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENCY   | (TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREI<br>TAI | *IX            | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | ULD BE                   | COMPLETION DATE       |
| F 280                    | Resident #6 was an November 5, 2010, 23, 2010, with diag Failure, Deep Vent Abuse, Supraventr and Failure to Thristone of the initial tour on Nove revealed a red biohazard bag in observation of the indicate the resident further medical remursing care plan in the resident's need specific precaution care.  Interview with the I December 2, 2010 office, revealed the isolation for Hepat no care plan in the of the need for cor Resident #26 was November 4, 2010 Congestive Heart Disease, Coronary Mellitus, Hyperten | ed:  dmitted to the facility on , and readmitted on November noses including Respiratory ous Thrombosis, Alcohol icular Tachycardia, Hepatitis B, ve.  resident's room during the mber 30, 2010, at 10:00 a.m., nazard bag in the trash can and the linen hamper. Continued room revealed no signage to not was on isolation.  cord review revealed no present in the record to reflect if for isolation precaution or at 0:30 a.m., in the DON's a resident was on contact itis B and confirmed there was a record and no documentation intact isolation precautions.  admitted to the facility on the property of Artery Bypass Graft, Disbetes sion, Gastroesophageal Reflux |                   | 280            | Changes in resident care wimmediately updated for all three residents to their care plans reflecting the need for isolation precautions and/or any specific precautions to observe for the residents. The MDS co-ordinator received physician orders and updated care plans for residents #6, #26, and #  The facility procedure has been updated to include obtaining physician orders for contact isolation and updating the care plans to reflect the need for isolation precautions with the residents. This policy was placed into facility use on 12/8/2010. Staff was in-set and policy manual updated 12/8/2010. | r<br>r<br>88.            | 12/8/2010             |
|                          | Mellitus, Hyperten:<br>Disease, and Tran   | sion, Gastroesophageal Reflux<br>Islent Ischemic Attack   |                   |                | !  |                          |                       |

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 12/02/2010 e, WING 445419 STREET ADORESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 318 BILBREY STREET OVERTON COUNTY NURSING HOME LIVINGSTON, TN 38570 PROVIDER'S PLAN OF CORRECTION COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PREGEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4) IP PREFIX REGULATORY OR LICE IDENTIFYING INFORMATIONS TAG DEFICIENCY DAT The Director of Nursing and F 280 Continued From page 2 F 280 Quality Assurance Nurse will monitor infections through the Medical record review of a nursing note dated November 21, 2010 at 4:00 p.m., revealed infection monitor sheet and "Wound care done to posterior thigh. Dark red, charge nurses have been purple area approx (approximately) 10 cm in-serviced to notify the QA (centimeters) x 10 cm. Has area in center 2.5 cm nurse when any new infection x 2.5 cm with 2 pinpoint open areas with thick yellow drainage." Further medical record review arises that is communicable. of a nursing note dated November 23, 2010, at This will ensure that 8:50 a.m., revealed "...wound oulture of resident all infection control measures received with MRSA (Methicillin Resistant Staphylococcus Aureus) in wound." are in place. Tracking of facility infections Observation of the resident's room during initial will continue with the Director tour on November 30, 2010, at 10:15 a.m., of Nursing and the QA meeting revealed no sign on the door indicating the will discuss the adherence to resident was on contact isolation. new procedure for contact Medical record review revealed no nursing care isolation precautions for the plan in the record to reflect the resident's need for isolation precautions or specific precautions to be quality assurance program in facility. The facility will include observed with dressing changes. Infection Control in the Safety Interview with the DON on December 2, 2010, at In-Services and meetings. 9:30 a.m., in the DON's office, confirmed the CDC guidelines state that the resident was on contact isolation for MRSA and there was no nursing care plan in the record of 'combination of infection control documentation of the need for contact isolation and a safety campaign is more precautions. effective in retention of proper Resident #8 was admitted to the facility on August 2, 2010, with diagnoses including Cervical Spinal technique and procedure for Stenosis, Hypertension, and Cerebral Vascular contact isolation then addressing Accident. it singularly' with blood borne pathogen instruction or infection Medical record review of the Fall Risk Assessment dated August 2, 2010, revealed the control instruction. (CDC guidelines I.D.2.a, for Long Term resident at risk for falls. 12/8/2010

Medical record review of the Assisted Transfer

Care Facilities)

HEALTH CARE FACILITY

PAGE 07/21 PRIN1EU; 12/08/2014 FORM APPROVED OMB NO. 0938-0391

| DELVIZIO                          | C EUD WEDICARE  | & MEDICAID SERVICES   | OMB NO, 0938-039   |     |   |  |                            |  |  |
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|                                   | •   | 445419  | . B. WIN           |     |   | 12/02                                    | 2010                       |  |  |
|                                   | ROVIDER OR SUPPLIER<br>N COUNTY NURSING   | S HOME  |                    | 318 | THE ADDRESS, CITY, STATE, ZIP CODE<br>BILBREY STREET<br>JINGSTON, TN 38570  |  |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG          | ACA CH DEFICIENC  | ATEMENT OF DEFICIENCES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | TION<br>LILD BE<br>COPRIATE              | CAS)<br>COMPLETION<br>DATE |  |  |
| F 280<br>F 323<br>SS=D            | Policy revealed " alone, two persons assist the resident turn the resident a Medical record rev August 11, 2010, r addressing the use Interview with MD: December 2, 2010 Plan Coordinator's had not been revis belt for transfers. 483,25(h) FREE C HAZARDS/SUPEI The facility must e environment rema | If the resident cannot stand (one on each side) should to stand using a gait belt, and hid sit him/her in the chair"  Ilew of the Care Plan dated evealed no documentation e of a gait belt with transfers.  E/Care Plan Coordinator, on a 1, at 1:15 p.m., in the MDS/Care office, confirmed the care plan ed to reflect the use of a gait  OF ACCIDENT  RVISION/DEVICES  Insure that the resident insure that the resident hazards deach resident receives sion and assistance devices to |                    | 323 | Resident # 8 care plan was immediately updated to rethe use of gait belt with trawith the resident.  The MDS co-ordinator with update care plans to include the residents of the plans to include the residents per our facility presidents per our facility presidents.    | flect<br>insfers<br>ll<br>le the<br>with |                            |  |  |
|                                   | by: Based on medica review, and interv implement a trans of twenty-six resid The findings inclu Resident #8 was 2 2010, with diad   |   |                    |     | The QA nurse will monitousing an audit of a selection charts with residents using assistive devices. This will done monthly and the QA will give direct feedback MDS coordinator on any deficiencies found in the plan. Quarterly findings be reported to the QA committee. | on of  Ill be Inurse to the              | ·                          |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B, WING 12/02/2010 445419 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 318 BILDREY STREET OVERTON COUNTY NURSING HOME LIVINGSTON, TN 38570 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR USC IDENTIFYING INFORMATION) ID PŘEFIX (X4) ID PREFIX DATE TAG DEFICIENCY) TAG F 323 Continued From page 4 F 323 Nursing staff was in-serviced Medical record review of the Minimum Data Set on proper use of gait belts (MDS) dated August 5, 2010, revealed the resident had impaired short/long term memory, and assistive devices. total dependence for ambulation, and required The QA nurse and Director two plus persons assist for transfers. of Nursing will perform weekly checks with staff Medical record review of a Fall Risk Assessment dated August 2, 2010, revealed the resident at to observe for gait belts and risk for falls. use of assistive devices. necessary corrections will Medical record review of the Assisted Transfer Policy revealed "...If the resident cannot stand be made and the QA nurse glone, two persons (one on each side) should will report findings to the assist the resident to stand using a gait belt, and quality assurance committee. 12/8/2010 turn the resident and sit him/her in the chair..." Medical record review of a Nurse's Notes dated September 27, 2010, revealed "...Resident falled to bear weight et (and) assisted to floor during transfer from shower chair to wheelchair..." Continued medical record review revealed no documentation that a gait belt had been used for the transfer. Interview with Licensed Practical Nurse #4, on December 1, 2010, at 10:50 a.m., in the nurse's office confirmed the facility failed to follow the Assisted Transfer Policy and a galt belt had not been used to assist with a transfer on September 27, 2010. F 441 483,65 INFECTION CONTROL, PREVENT F 441 SPREAD, LINENS \$\$**=**≝ The facility must establish and maintain en Infection Control Program dealgned to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

DEPARTMENT OF HEALTH AND h AN SERVICES

HEALTH CARE FACILITY

PAGE 09/21 PRINTED: 12/05/2010 FORM APPROVED OMB NO. 0938-0391

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|                          | •   | 445419   | B. Wil      | NG  |  | 12/02/                    | 2010               |
|                          | ROVIDER OR SUPPLIER<br>IN COUNTY NURSIN   | <u> </u>   |             | 3   | EET ADDRESS, CITY, STATE, ZIP CODE<br>18 BILBREY STREET<br>IVINGSTON, TN 38570   |                           |                    |
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| F 441                    | Continued From p  | age 5  | F           | 441 |  | Ì                         |                    |
|                          | Program under wh<br>(1) Investigates, or<br>in the facility;<br>(2) Decides what is<br>should be applied  | stablish an Infection Control ich it - controls, and prevents infections concedures, such as isolation, to an individual resident; and cord of incidents and corrective  |             |     |  |                           |                    |
|                          | (b) Preventing Spi<br>(1) When the Infer<br>determines that a<br>prevent the sprea-<br>isolate the resider<br>(2) The facility mu-<br>communicable dis-<br>from direct contact<br>direct contact will<br>(3) The facility mu-<br>hands after each | read of Infection ction Control Program resident needs isolation to d of infection, the facility must it est prohibit employees with a sease or Infected skin lesions it with residents or their food, if transmit the disease. The facility must transmit the contact for which indicated by accepted | ·           |     |  |                           |                    |
|                          | (c) Linens<br>Personnel must h<br>transport linens s<br>Infection.  | nandle, store, process and of as to prevent the spread of  | -           |     |  |                           |                    |
|                          | by: Based on medical policy, observation failed to implement the softer   | ENT is not met as evidenced all record review, review of facility an, and interview, the facility ant infection control practices to ad of infection for six (#6, #18, 25) of twenty-six residents   |             |     |  |                           |                    |

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|                          | •   | 445419  | B. Will           |          |  | 12/0  | 2/2010             |
|                          | ROVIDER OR SUPPLIER   |   |                   | 31       | BET ADDRESS, CITY, STATE, ZIP CODE<br>8 BILBREY STREET   | ,   | ,                  |
| OVERTO                   | N COUNTY NURSING  | 3 HOME  |                   | n        | VINGSTON, TN 38570   |   | <del>,</del>       |
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| F 441                    | Continued From Pa   | age 6   | F                 | 441      |  |   |                    |
|                          | Resident #6 was a November 5, 2010, 23, 2010, with diagraiture, Deep Ven Abuse, Supravent and Failure to Through Continued observation of the tour on November revealed a red biowaste) in the traisiblohazard/blodage Continued observationage to indicate Further observationage to indicate revidence of perso (gowns, masks) of Medical record rethe resident was Review of facility revealed "Isolation door of rooms with precautions." The Not Enter Room for instructions." revealed "Contact transmission of it epidemiologically diseases or condare spread prima Thus mask, gow for anyone in direct contact any contact anyone in direct contact anyone in direct contact anyone in direct contact anyone in direct contact any contact | idmitted to the facility on and readmitted on November gnoses including Respiratory bus Thrombosis, Alcohol ricular Tachycardla, Hepatitis B, ive.  The resident's room during initial of 30, 2010, at 10:00 a.m., shazard bag (used for infectious of an and a radable bag in the linen hamper, without of the room revealed no see the resident was on isolation on of the room revealed no onal protective equipment other than disposable gloves. |                   |          | Primary care physician for resident # 6 was contacted order written for contact isolation. Sign was placed of resident's room immedia with additional signs availate nursing staff in all crash in facility. Mask, gowns, a gloves were placed outside resident's room on a table. Disposable bags and Bioha bags were placed on table of resident's room. Non-vital equipment was president's room. Antisepticand disposable gloves were in resident's room.  The MDS coordinator updaplan of care to reflect the nof isolation precautions for resident. | outside ately able carts and of zard outside caced in the caced ated the ecessity | ie                 |

HEALTH CAME FAMILLIN אואווויובט: יובאיטמוציייי 8655545735 12/08/2010 09:32 FORM APPROVED IN SERVICES DEPARTMENT OF HEALTH AND H OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 12/02/2010 e, WNG 445419 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 218 BILBREY STREET OVERTON COUNTY NURSING HOME LIVINGSTON, TN 38570 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DUS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG DEFICIENCY) F 441 Continued From page 7 F 441 Interview with the DON (Director of Nursing) on December 2, 2010, at 9:00 a.m., in the DON's office, confirmed the resident was on contact isolation precautions for Hepatitis B and there was no sign on the resident's door indicating the resident was on isolation. Continued interview with the DON revealed gloves and masks were available at the nurses' station and gowns were available in central supply, but were not routinely

Resident #18 was admitted to the facility on May 30, 2003, and readmitted on June 27, 2009, with diagnoses including Myelodysplastic enemia, Coronary Artery Disease, Gastroesophageal Reflux Disease, and Neurogenic Bladder.

stocked in the resident's room.

Medical record review of a physician's note dated August 9, 2010, revealed "C-diff (Clostridium Difficile) with coplous watery, liquid, brown diarrhea." Continued medical record review of a physician's note dated September 14, 2010, revealed "C-diff culture positive."

Further medical record review revealed no documentation the resident was placed on contact isolation precautions.

Interview with the DON on December 2, 2010, at 9:30 a.m., In the DON's office, confirmed the resident was placed on contact isolation precautions for C-diff in stool:

Interview with the Wound Care Coordinator on December 2, 2010, at 12:40 p.m., in the conference room, confirmed there was no documentation in the medical record to reflect the resident was placed on isotation precautions or

Resident #18 was not placed on isolation precautions again secondary to follow up lab work stating negative culture for C-diff on 9/12/2010.

Nursing staff was in-serviced on the updated nursing procedure for contact isolation. Procedure states that the charge nurse obtain a physician order for contact isolation and must document this order for necessity of isolation precautions. HEALTH CARE FACILITY

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| DEPART                   | MENT OF HEALTH  | AND HL IN SERVICES  |                   |     |  | OMB NO.  | 938-0391        |
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|                          |   | 445419  | B. WIA            |     |  | 12/02  | /2010           |
|                          | ROVIDER OR SUPPLIER   | 3 HOME  | <u> </u>          | 31  | EET ADDRESS, CITY, STATE, 219 CODE<br>18 BILBREY STREET<br>N'INGSTON, TN 38576   | ·  |                 |
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| F 441                    | Resident #28 was<br>November 4, 2010  | admitted to the facility on<br>b, with diagnoses including<br>Failure, Coronary Artery  | F                 | 441 | ·  |  |                 |
|                          | Disease, Coronary Melitus, Hypertan Disease, and Trar Medical record revolution of the November 21, 20 "Wound care done purple area appropriate area biohazard/biod hamper. Further personal protection disposable area area appropriate area appropriate area appropriate area area appropriate area area area area area area area a | y Artery Bypass Grart, Diabetes sion, Gastroesophageal Reflux instent Ischemic Attack.  view of a nursing note dated to at 4:00 p.m., revealed to posterior thigh. Dark red, ox (approximately) 10 cm. It is area in center 2,5 cm inpoint open areas with thick. Further medical record review dated November 23, 2010, at ed."wound culture of resident SA (Methicillin Resistant Aureus) in wound."  e resident's room during Initial or 30, 2010, at 10:15 a.m., on the door indicating the solation. Continued observation ohazard bag in the trash can and egradable bag in the linen to observation revealed no ve equipment in the room other |                   |     | Primary care physician for resident # 26 was contacted order written for contact isolation. Sign was placed of resident's room immedia with additional signs availate to nursing staff in all crash in facility. Mask, gowns, a gloves were placed outside resident's room on a table. Disposable bags and Bioha bags were placed on table of resident's room.  Non-vital equipment was president's room. Antiseptiand disposable gloves were in resident's room.  The MDS coordinator upd plan of care to reflect the resident of the residen | outside ately able carts and of azard outside blaced in the c solution e placed ated the necessity | e               |

HEALTH CARC FACILITY

PAGE 13/21 PRINTED: 12/06/2010 FORM APPROVED OMB NO. 0938-0391

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| ND PLAN OF               | CORRECTION   | DENTIFICATION NUMBER:  | V Bri            | LDING |   | }  |                    |
|                          |  | 445419   | B. Wit           | 4G    |   | 12/02/2  | 2010               |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                  | BTR   | EET ADDRESS, CITY, STATE, ZIP OODE  |  |                    |
|                          | N COUNTY NURSIN  | G HOME   |                  |       | is Bilbrey Street<br>Wingston, TN 28570   |  |                    |
| OVERTO                   |  |  |                  |       | PRIMITERS PLAN OF CORRECT   | TION   | (745)<br>CMPLETION |
| (X4) (D<br>PREFIX<br>TAG | SUMMARY ST<br>(EACH DEFICIENC<br>REGULATORY OR   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  | D<br>PREP<br>TAC |       | (BACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)  | BOPRIATE   | DATE               |
| F 441                    | 9:00 a.m., in the I resident was on cand there was no indicating the resident was no indicating the resident was no indicating the resident wound of the wound applied two glove the wound as a Smeasuring 6.0 cm. wide, with a smeasuring from the wound with wound continued observing glove from the perimeter of the a gauze pad, applied incontinuence can of fecal incontin | DON on December 2, 2010, at DON's office, confirmed the contact isolation due to MRSA sign on the resident's door dent was on isolation.  Covember 30, 2010, at 2:10 p.m., covember 410, and described stage IV pressure ulcer in (centimeters) in length and 5.0 slight amount of serous vation revealed LPN #1 removed the ideanser and a gauze pad, vation revealed LPN #1 removed the left hand and cleaned the wound with wound cleaned the wound with wound cleaned the wound with wound cleaned the gloves and without washing the gloves and provided a to the resident after an episode of the gloves and applied cleans linens to the gloves and applied cleans linens to ad, then removed the gloves and discussive policy Hand Washing |                  | 441   | The Director of Nursing and Quality Assurance Nurse w monitor infections through infection monitor sheet and charge nurses have been in-serviced to notify the QA nurse when any new infection arises that is communicable. This will ensure that all infection control measure in place.  Tracking of facility infection will continue with the Dire of Nursing and the QA measure in places and the QA measure in procedure for contact isolation precautions for the quality assurance program facility. The facility will infection Control in the Sa In-Services and meetings. | the  the  on  c.  res  ons  ctor  eting  to  e  in  nclude  fety | 2/8/2010           |
|                          | revealed "Han<br>between proced  | d washing should be performed  |                  |       | Feeliav ID: TN8702 If co  | nlinuation sheet   | Dage 40 st         |

PAGE 14/21 PRINTED: 12/08/2010 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER: A, BUILDING 12/02/2010 B. WING 446419 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 318 BILBREY STREET LIVINGSTON, TN 28570 OVERTON COUNTY NURSING HOME PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (305) COMPLETION CATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION) Ю PREFIX TAG (X4) ID PREFIX DEFICIENCY) TAG F 441 The facility policy on Hand Continued From page 10 F 441 Washing now includes Interview on December 2, 2010, at 8:55 a.m., with Hand Hygiene. the Director of Nursing (DON), in the DON's The facility will continue office, revealed the hands were to be washed and following the hand washing after cleaning a wound prior to applying a clean protocol between procedures dressina. but will allow the use of hand Interview on November 30, 2010, at 3:00 p.m., sanitizer and hand hygiene or with LPN #1, in the nursing office, revealed the hands were to be washed after providing wound hand washing between care and after providing incontinence care. procedures. This policy Continued interview confirmed the hands were was updated and put into not washed after cleaning the wound prior to applying a clean dressing, after providing wound place on the day the care prior to providing incontinence care, and staff was in-serviced on the after providing incontinence care prior to placing new policy. clean linens on the resident's bed. Observation on November 30, 2010, at 11:20 The QA nurse and/or Director a.m., during a medication pass on Wing 3, Of Nursing will observe 12/8/2010 revealed LPN #2, with gloved hands, entered the the wound care nurse room of resident #13. Further observation perform wound care as part of revealed LPN #2 did not wash hands prior to removing a bottle of Nedmycin, Polymixin B, QA rounds on a weekly Hydrocortisone (Cortisporin) Ophthalmic basis. Compliance and Suspension (antibiotic medication for eye proper technique will infection) from a plastic bag previously stored in be observed according to the Wing 3 Men's medication cart. Further observation revealed LPN #2, with gloved hands, facility procedure and policy. left the resident's bedside to look Wing 3 Men's The quality assurance committee medication cart, located at the entrance of the will be informed of findings and resident's room; returned to the resident's follow up on any corrections bedside; held the bottle of Neomycin, Polymixin B, Hydrocortisone (Cortisporin) Ophthalmic or suggestions to meet suspension in the gloved hands; administered two compliance. drops to each eye of resident #13; removed the gloves from hands; and exited the room without washing hands after administering the eye drops.

## DEPARTMENT OF HEALTH AND HU. AN SERVICES

| DEPARTI                  | MENT OF HEALTH  | AND HOUSE SERVICES  |   |          |  |                        | (930-039)       |
|--------------------------|---|---|---|----------|--|------------------------|-----------------|
| CENTER                   | S FOR MEDICARE  | 8 MEDICAID SERVICES  K1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:   | (X2) MI   |          | PLE CONSTRUCTION   | (X3) DATE SU<br>COMPLE | JRVEY<br>TED    |
| ID PLAN OF               | CORRECTION  | 445419  | B. WIL  |          |  | 12/0                   | 2/2010          |
|                          | ROVIDER OR SUPPLIER<br>N COUNTY NURSIN  |   | STREET ADDRESS, CITY, STATE, ZIP CODE 218 BILBREY STREET LIVINGSTON, TN 38570 |          |  |                        |                 |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY ST  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC   | J<br>PIX | PROVIDER'S PLAN OF CA<br>(EACH CORRECTIVE ACTION<br>(EACH CORRECTIVE ACTION<br>(EACH CORRECTIVE ACTION OF THE<br>PROVIDER OF THE CASE OF T | E APPROPRIATE          | DOMPLETION DATE |
| F 441                    | Continued From p Review of manufa Cortisporin Ophth "Information for P handled improper common bacteria infections. Sericus subsequent loss of contaminated pro Review of facility Administration re administer ophtha around the eye, is STANDARD3. Wash hands (ext applied)9. Inst hands"  Interview with LF 11:30 a.m., at the outside the room hands were not sudministration of gloved hands with hands were not sudministration of gloved hands with hands were not sudministration cant medication cant medication cant eye drops.  Interview with th December 1, 20 office confirmed and after edmin facility policy an administering e | age 11 cturer's specifications for almic Suspension revealed attentsocular products, if ly, can become contaminated by known to cause ocular stamminated to the eye and of vision may result from using ducts"  policy Eye Ointment/Drops vealed "PURPOSE To almic ointment/drops into and a safe and accurate manner. Explain procedure to resident. 4 amination gloves may be iff medication15. Wash  IN #2 on November 30, 2010, at a Wing 3 Men's medication cart in of resident #13, confirmed the washed before and after the fleye drops to resident #13 and are contaminated when touching ge bag previously located on the prior to the administration of the life Director of Nursing (DON), on 110, at 1:30 p.m., in the DON's inhands are to be washed before istering eye drops to residents put of not contaminated prior to the drops to any resident. | er  | 441      |  |                        |                 |
|                          |   | November 30, 2010, at 3:17 p.m<br>ation pass on Wing 2, revealed<br>loved hands, entered the room of  |   |          |  | if continuation s      | heat Page 12    |
| <b></b>                  |   | Event ID:OH   | (0211   |          | Facility ID: TNB702  | it colingranation a    | mear roller to  |

HEALTH CARE FACILITY

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12/08/2010 09:32 FORM APPROVED DEPARTMENT OF HEALTH AND HU. N SERVICES OMB NO 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (XX) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: a Building B. WING 12/02/2010 445419 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 348 BILBREY STREET OVERTON COUNTY NURSING HOME LIVINGSTON, TN 38570 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ID PREFIX PREFIX DATE TAG DEFICIENCY) TAG Nurses # 1, #2 and #3 were F 441 Continued From page 12 F 441 present for the in-service resident #25. Further observation revealed LPN on the updated policy and #3 did not wash hands prior to removing a bottle procedure for hand washing/hand of Dorzolamide and Timolol (Cosopt) Ophthelmic Solution (medication for glaucoma) from a plastic hygiene. The in-service was . storage bag previously stored in the Wing 2 Long held with nursing staff and Hall cart. Further observation revealed LPN #3 administered one drop of ophthalmic medication questions and answers were to each eye of resident #25; removed the gloves; discussed concerning proper and exited the room without washing hands after procedure. the administering the eye drops. The QA nurse will observe Interview with LPN #3, on November 30, 2010, at 3:25 p.m., at the Wing 2 Long Hall cart located nursing staff during outside the room of resident #25 confirmed the weekly compliance rounds hands were not washed before and after the to observe if proper procedure administration of eye drops to resident #25 and . is being followed and staff will gloves were contaminated after touching the plastic medication bag prior to administering the be in-serviced as needed and eve drops. re educated as needed. Interview with the DON, on December 1, 2010, at 1:30 p.m., in the DON's office confirmed hands The Quality Assurance are to be washed before and after administering Committee will be informed eye drops to residents per facility policy and not of findings of compliance contaminated prior to administering eye drops to rounds and follow up on

F 514 SS=D |

C/O #27122 483.75(I)(1) RES

any resident.

RECORDS-COMPLETE/ACCURATE/ACCESSIB

The facility must maintain clinical records on each resident in accordance with accepted professional etandards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient

F 514

12/8/2010

FORM CMS-2587(02-99) Provious Versione Obsolete

Event ID: OH0211

Feelity ID: TN8702

any corrections or suggestions

to meet compliance.

If continuation sheet Page 13 of 14

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HEALTH CARE FACILITY

PAGE 17/21 PRINTED: TAIUDIZUTU

FORM APPROVED DEPARTMENT OF HEALTH AND HULLAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: a building B. WING. 12/02/2010 445419 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 318 BILBREY STREET OVERTON COUNTY NURSING HOME LIVINGSTON, TN 38570 PROVIDER'S PLAN OF CORRECTION COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XA) ID PREFIX PREFIX DATE TAG TAG DEFICIENCY) F 514 Continued From page 13 F 514 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State: and progress notes. This REQUIREMENT is not met as evidenced bv: Based on medical record review and interview the facility failed to maintain a complete and accurate olinical record for one resident (#20) of twenty-six residents reviewed. The findings included: Resident # 20 physician Resident #20 was admitted to the facility on orders were updated February 23, 2009 with diagnoses including to reflect DNR status. Dementia, Psychosis, Benign Prostatic To reflect changes in Hypertrophy, and Atrial Fibrillation. Status of residents the Medical record review of the monthly Facility implements recapitulation orders dated November and A "change of status" December 2010 revealed the resident's Code Status as "Full Code" (Resuscitate/CPR). form. This form will

FORM CMS-2867(02-99) Provious Versions Obsoleta

Medical record review of the resident's POST

Interview with the Director of Nursing on

December 2, 2010, at 10:30 a.m., in the

resident's current code status.

conference room confirmed the resident's medical record was not updated to reflect the

(Physician Orders for Scope of Treatment) dated

October 22, 2010, revealed the resident's Code Status as "Do Not Resuscitate (DNR/no CPR)."

Event ID: OH0211

Facility ID: TN8702

now include Code

can update this information.

Nursing staff was

In-serviced on this

Services Director will write the status on the change of status

procedure, the Social

Status and be passed

to departments which

If continuation sheet Page 14 of 14